HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 1/1/2009)

First follow these orders, then contact physician. This is a Physician Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Last Name	
First /Middle Name	
Date of Birth	Date Form Prepared

A — CARDIOPULMONARY RESUSCITATION (CPR): *Person has no pulse and is not breathing.*

Check One

☐ **Attempt Resuscitation/CPR** ☐ **Do Not Attempt Resuscitation/DNR (Allow Natural Death)**
(Section B: Full Treatment required)

When not in cardiopulmonary arrest, follow orders in **B** and **C**.

B — MEDICAL INTERVENTIONS: *Person has pulse and/or is breathing.*

Check One

☐ **Comfort Measures Only** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Antibiotics only to promote comfort. ***Transfer*** *if comfort needs cannot be met in current location.*

☐ **Limited Additional Interventions** Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Do Not Transfer to hospital for medical interventions. Transfer*** if comfort needs cannot be met in current location.

☐ **Full Treatment** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. ***Transfer*** *to hospital if indicated. Includes intensive care.*

Additional Orders: _____

_____

C — ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible and desired.*

Check One

☐ No artificial nutrition by tube. ☐ Defined trial period of artificial nutrition by tube.

☐ Long-term artificial nutrition by tube.

Additional Orders: _____

D — SIGNATURES AND SUMMARY OF MEDICAL CONDITION:

Discussed with:

☐ Patient ☐ Health Care Decisionmaker ☐ Parent of Minor ☐ Court Appointed Conservator ☐ Other:

Signature of Physician

My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Print Physician Name	Physician Phone Number	Date
Physician Signature (required)	Physician License #	

Signature of Patient, Decisionmaker, Parent of Minor or Conservator

By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Signature (required)	Name (print)	Relationship (write self if patient)

Summary of Medical Condition	Office Use Only

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Patient Name (last, first, middle)	Date of Birth	Gender: ☐ M ☐ F
Patient Address		

Contact Information

Health Care Decisionmaker	Address		Phone Number
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

Directions for Health Care Professional

Completing POLST

- Must be completed by health care professional based on patient preferences and medical indications.
- POLST must be signed by a physician and the patient/decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- Certain medical conditions or medical treatments may prohibit a person from residing in a residential care facility for the elderly.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- No defibrillator (including automated external defibrillators) should be used on a person who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- Treatment of dehydration prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment."

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.

Modifying and Voiding POLST

- A person with capacity can, at any time, void the POLST form or change his/her mind about his/her treatment preferences by executing a verbal or written advance directive or a new POLST form.
- To void POLST, draw a line through Sections A through D and write "VOID" in large letters. Sign and date this line.
- A health care decisionmaker may request to modify the orders based on the known desires of the individual or, if unknown, the individual's best interests.

California Coalition for Compassionate Care

The Coalition is the lead agency for implementation of POLST in California. This form is approved by the Emergency Medical Services Authority in cooperation with the California Coalition for Compassionate Care and the statewide POLST Task Force.

For more information or a copy of the form, visit **www.finalchoices.org**.

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

CMA PUBLICATIONS 1(800) 882-1262 www.cmanet.org

EMERGENCY MEDICAL SERVICES
PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM

Purpose

The Prehospital Do Not Resuscitate (DNR) Form has been developed by the California Emergency Medical Services Authority, in concert with the California Medical Association and emergency medical services (EMS) providers, for the purpose of instructing EMS personnel to forgo resuscitation attempts in the event of a patient's cardiopulmonary arrest. Resuscitative measures to be withheld include chest compression, assisted ventilation, endotracheal intubation, defibrillation, and cardiotonic drugs. The form does **not** affect the provision of other emergency medical care, including palliative treatment for pain, dyspnea, major hemorrhage, or other medical conditions.

Applicability

This form was designed for use in **prehospital settings** – i.e., in a patient's home, in a long-term care facility, during transport to or from a health care facility, and in other locations outside acute care hospitals. However, hospitals are encouraged to honor the form when a patient is transported to an emergency room. California law protects any health care provider (including emergency response personnel) who honors a properly completed Prehospital Do Not Resuscitate Form (or an approved wrist or neck medallion) from criminal prosecution, civil liability, discipline for unprofessional conduct, administrative sanction, or any other sanction, if the provider believes in good faith that the action or decision is consistent with the law and the provider has no knowledge that the action or decision would be inconsistent with a health care decision that the individual signing the request would have made on his or her own behalf under like circumstances. This form does not replace other DNR orders that may be required pursuant to a health care facility's own policies and procedures governing resuscitation attempts by facility personnel. Patients should be advised that their prehospital DNR instruction may not be honored in other states or jurisdictions.

Instructions

The Prehospital Do Not Resuscitate (DNR) Form must be signed by the patient or by an appropriate surrogate decisionmaker if the patient is unable to make or communicate informed health care decisions. The surrogate should be the patient's legal representative (e.g., a health care agent, a court-appointed conservator, a spouse or other family member) if one exists. The patient's physician must also sign the form, affirming that the patient/surrogate has given informed consent to the DNR instruction.

The **first copy** of the form should be retained by the patient. *The completed form (or the approved wrist or neck medallion – see below) must be readily available to EMS personnel in order for the DNR instruction to be honored.* Resuscitation attempts may be initiated until the form (or medallion) is presented and the identity of the patient is confirmed.

The **second copy** of the form should be retained by the physician and made part of the patient's permanent medical record.

The third copy of the form may be used by the patient to order an optional wrist or neck medallion inscribed with the words "DO NOT RESUSCITATE-EMS." The Medic Alert Foundation (1-888-755-1448, 2323 Colorado Avenue, Turlock, CA 95381) is an EMS Authority-approved supplier of medallions, which will be issued only upon receipt of a properly completed Prehospital Do Not Resuscitate (DNR) Form (together with an enrollment form and the appropriate fee). Although optional, use of a wrist or neck medallion facilitates prompt identification of a patient, avoids the problem of lost or misplaced forms, and is strongly encouraged.

Revocation

If a decision is made to revoke the DNR instruction, the patient's physician should be notified immediately and all copies of the form should be destroyed, including any copies on file with the Medic Alert Foundation or other EMS Authority-approved supplier. Medallions and associated wallet cards should also be destroyed or returned to the supplier.

Questions about implementation of the Prehospital Do Not Resuscitate (DNR) form should be directed to the local EMS agency.

EMERGENCY MEDICAL SERVICES
PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM

An Advance Request to Limit the Scope of Emergency Medical Care

I, _____ , request limited emergency care as herein described.
(print patient's name)

I understand DNR means that if my heart stops beating or if I stop breathing, no medical procedure to restart breathing or heart functioning will be instituted.

I understand this decision will not prevent me from obtaining other emergency medical care by prehospital emergency medical care personnel and/or medical care directed by a physician prior to my death.

I understand that I may revoke this directive at any time by destroying this form and removing any "DNR" medallions.

I give permission for this information to be given to the prehospital emergency care personnel, doctors, nurses or other health personnel as necessary to implement this directive.

I hereby agree to the "Do Not Resuscitate" (DNR) order.

_____ _____
Patient/Surrogate Signature Date

_____
Surrogate's Relationship to Patient

By signing this form, the surrogate acknowledges that this request to forgo resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of this form.

I affirm that this patient/surrogate is making an informed decision and that this directive is the expressed wish of the patient/surrogate. A copy of this form is in the patient's permanent medical record.

In the event of cardiac or respiratory arrest, no chest compressions, assisted ventilations, intubation, defibrillation, or cardiotonic medications are to be initiated.

_____ _____
Physician Signature Date

_____ _____
Print Name Telephone

THIS FORM WILL NOT BE ACCEPTED IF IT HAS BEEN AMENDED OR ALTERED IN ANY WAY

PREHOSPITAL DNR REQUEST FORM

Copy 1 – To be kept by patient

EMERGENCY MEDICAL SERVICES
PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM

An Advance Request to Limit the Scope of Emergency Medical Care

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(print patient's name)

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I give permission for this information to be given to the prehospital emergency care personnel, doctors, nurses or other health personnel as necessary to implement this directive.

I hereby agree to the "Do Not Resuscitate" (DNR) order.

_____ _____
Patient/Surrogate Signature Date

_____
Surrogate's Relationship to Patient

By signing this form, the surrogate acknowledges that this request to forgo resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of this form.

I affirm that this patient/surrogate is making an informed decision and that this directive is the expressed wish of the patient/surrogate. A copy of this form is in the patient's permanent medical record.

In the event of cardiac or respiratory arrest, no chest compressions, assisted ventilations, intubation, defibrillation, or cardiotonic medications are to be initiated.

_____ _____
Physician Signature Date

_____ _____
Print Name Telephone

THIS FORM WILL NOT BE ACCEPTED IF IT HAS BEEN AMENDED OR ALTERED IN ANY WAY

PREHOSPITAL DNR REQUEST FORM

Copy 2 – To be kept in patient's permanent medical record

EMERGENCY MEDICAL SERVICES
PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM

An Advance Request to Limit the Scope of Emergency Medical Care

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(print patient's name)

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I hereby agree to the "Do Not Resuscitate" (DNR) order.

_____ _____
Patient/Surrogate Signature Date

_____
Surrogate's Relationship to Patient

By signing this form, the surrogate acknowledges that this request to forgo resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of this form.

I affirm that this patient/surrogate is making an informed decision and that this directive is the expressed wish of the patient/surrogate. A copy of this form is in the patient's permanent medical record.

In the event of cardiac or respiratory arrest, no chest compressions, assisted ventilations, intubation, defibrillation, or cardiotonic medications are to be initiated.

_____ _____
Physician Signature Date

_____ _____
Print Name Telephone

THIS FORM WILL NOT BE ACCEPTED IF IT HAS BEEN AMENDED OR ALTERED IN ANY WAY

PREHOSPITAL DNR REQUEST FORM

Copy 3 – If authorized DNR medallion desired, submit this form with Medic Alert enrollment form to: Medic Alert Foundation, Turlock CA 95381